9, NO. 3 1970

Inventory

A QUARTERLY JOURNAL ON ALCOHOL AND ALCOHOLISM
PUBLISHED BY THE N. C. DEPARTMENT OF MENTAL HEALTH

TREATMENT

REHABILITATION

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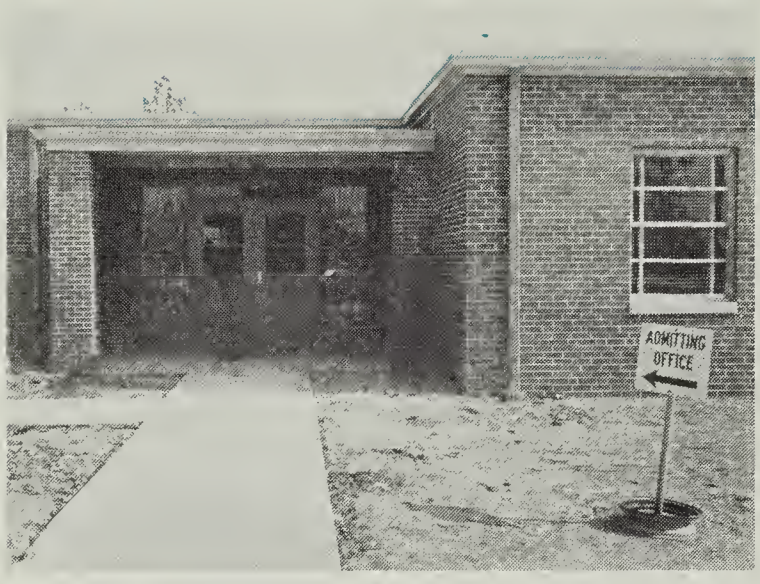

ARC AT Butner,

ARC at Black Mountain, Western Region

ARC at Greenville, Eastern Region

About the ARC's . . .

The ARC's, operated by the N. C. Department of Mental Health, are in-residence treatment facilities for persons with alcoholism. For the majority of patients the length of stay is 28 days. A fee of $7 per day is charged for the four weeks of treatment. This may be paid by cash or check at the time of admission or by an agreement signed by the patient promising to pay the full sum at some time after discharge. If a person is indigent he may obtain a letter from his local department of social service stating this fact and, upon presentation of this letter, request for payment will be deferred. No patients are refused treatment because of lack of money.

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ARC's

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INVENTORY

WINTER ISSUE

VOLUME 19, NO. 3 1970

RALEIGH, N. C.

An educational Journal on Alcohol and Alcoholism. Published quarterly by the N. C. Department of Mental Health created by Section 122-1 of the General Statutes of North Carolina. Former Section 122-1 was redesignated by Session Laws 1963 c. 1166, s. 2, as Section 122-7. Section 3 of the 1963 act added present Section 122-1. Offices are located at 441 North Harrington Street, Raleigh, N. C. 27603.

LILLIAN PIKE
Editor

ELEANOR BROOKS
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This journal is printed as a public information service. Persons desiring a place on the free mailing list must send in a written request, with the exception that *new* requests from *individuals* residing outside North Carolina can no longer be accepted. The views expressed in the articles published are those of the authors and not necessarily those of *Inventory*. Manuscripts are invited with the understanding that no fees can be paid.

Write: INVENTORY, P. O. Box 26327, Raleigh, North Carolina 27611.

SECOND-CLASS POSTAGE PAID AT RALEIGH, N. C. 27611

Industries' Five Percent Illness

BY NORMAN BENN

Norman Benn, above, is a field representative of the Alcoholism Program of the Washington State Department of Health. He prepared this article, reprinted here by permission, for **Focus**, a publication of the department.

The June, 1969, reprint from the Texas Business Review states, "Alcoholism in National industry is a $4 Billion hangover for the country."

Dun and Bradstreet estimate a much higher annual national loss figure of $7.5 billion, pointing out that after a three-martini lunch an executive with the power to negotiate and sign contracts could cost a company "$1 million in five minutes."

The actual cost to Industry nationwide is only an estimate, but there are enough concrete facts available to show the cost of alcoholism, or problem drinking, to industry to be staggering.

Several companies have conceded that when they started alcoholism programs, their progress was impeded by using the term "alcoholic". The majority of the general public still associate alcoholism or an alcoholic with the Skid Road derelict. The National Council on Alcoholism estimates that only 3 to 5 % of the nation's alcoholics qualify under this category. Since many industries are concerned with being able to identify the problem drinker before he becomes a full blown alcoholic, the word alcoholic will not be used in the rest of this report, other than to clarify a point.

It is estimated that the State of Washington has 86,000 problem drinkers. If as many as 5% were the Skid Road type, that still leaves us with 81,700 unaccounted for problem drinkers.

Many industries have come to accept problem drinking as a disease and thus have proceeded to implement a rehabilitation program for employees with this illness. They have started making progress against this disease simply because they believe in order to solve a problem, they must admit that a problem exists. Their financial people have found it is considerably less expensive to rehabilitate a problem drinker than to fire him, and train a replacement. Also, when you hire someone to replace the problem drinker you are never sure that you haven't hired another problem drinker!

We, as professionals working in this field, have an obligation to help industry understand this problem. Too many industries are not willing to admit they have any problem drinkers in their company. There are many

reasons for this, and possibly the best one is that they actually believe this, due to lack of education in this area.

How do we get industry to recognize the problem and then be willing to be a part of the solution? We do this through education, by being prepared to offer them workshops and hard, cold facts on problem drinking. Then, we show them positive solutions based on other companies' experiences.

Where do we start? We start at top management and with the unions. Assuming we are successful in selling our program, we may have to act as arbitrators to get the management and the unions to agree on the basic program to be offered the employees. The most important aspect to get across to management and the unions is that the backbone of the entire program rests with their supervisors. Unless they are trained and willing to accept their responsibility of helping problem drinkers the program will undoubtedly fail. This training we are able to provide—free—is a tremendous selling point on our side against alcoholism; use it!

The supervisors must be aware that this new job responsibility is a humane and worthwhile endeavor. They are not to become head hunters or detectives. They will be able to identify many of their problem drinkers by the following examples:

1. Work deterioration
2. Irritability
3. Hand tremors
4. Absenteeism
5. Inappropriate excuses and absences
6. Alcohol on breath
7. Accidents
8. Intoxication on the job

There are also basic steps a supervisor should take once he is sure he has a problem drinker working for him. Not only must he serve as the means of identifying the problem drinker, but also he must precipitate the job crisis by confronting the employee with his unsatisfactory job performance. The supervisor must talk to the man about his job ineffectiveness, never mentioning his drinking. He is only interested in job performance and must not get into the position of diagnosing. He will want to refer the man to their company doctor for a physical, giving the doctor what information he has. If the doctor feels there is a drinking problem, he will discuss it with the employee, and then make the proper referral.

This could be to a number of resources, preferably to an Alcoholism Information and Referral Center, for evaluation and referral. If the employee fails to follow through on the referral and continues his poor job performance once again he must be confronted by the supervisor and given, preferably, a 30-day suspension, with the opportunity of going to a treatment center and doing something about his problem.

You have to create a crisis in the problem drinkers' life. This is what you have done by the suspension. The problem drinker will never become a normal person unless he is made responsible for his actions.

Many industries do not have a company doctor. Thus, their personnel director will have to become educated on problem drinking so that he can present the facts to the employee and make the proper referral, which would be basically the same as a company doctor's suggestion.

Many industries boast a 60-90% success factor from problem drinkers they have helped get to treatment.

Now is the time for professional disciplines of Industry and our communities to correlate an effective attack on the problem of Alcoholism and problem drinking. We can only do this by involving our government, state, voluntary agencies, and private enterprise.

Patient Writes

I am about to complete 28 days at the Alcoholic Rehabilitation Center at Black Mountain, a very excellent place in every way. Please put me on your *inventory* mailing list.

ARC Patient
Asheville, N. C.

Used by Technical Institute

Please put me on your mailing list for *Inventory*. We will place it in the Practical Nurse Education Department at Haywood Technical Institute.

Ruby Lee Hinson, R. N.
Clyde, N. C.

Volunteer Group Leader

I have recently gone with the Randolph Clinic as a volunteer group leader, and am interested in obtaining your quarterly journal, *Inventory*.

Rev. R. C. Brand, Jr.
Charlotte, N. C.

Future Industrial Consultant

I am presently doing research for a Ph.D. degree in management at Murry State University, and plan to become a source person in the area of industrial alcoholism. My research deals with the "alcoholic executive." I would appreciate very much your making *Inventory* available to me.

R.B. Barton, Jr.
Murray, Kentucky

Staff Members Interested

Members of our staff have expressed an interest in receiving *Inventory* for inclusion in the library of the County Department of Health and Welfare. Please add us to your mailing list.

Mrs. Beverly A. Fox
San Mateo, California

Halfway House Facilities

If possible we would like to be placed on your list to receive *Inventory*. We are a private agency and provide halfway facilities for men and women alcoholics. Syracuse Brick House, Inc. is a control agency for the Department of Mental Health and a Community Thank you.

Rupert J. Collins
Syracuse, New York

ARC Psychiatric Aides

Please put the names below on your mailing list for *Inventory*. We are psychiatric aides at the Walter B. Jones Alcoholic Rehabilitation Center at Greenville. Thank you.

ARC Psychiatric Aides
Greenville, N. C.

State Hospital Unit

We have recently opened an Alcoholic Rehabilitation Unit in our state hospital. Would you please put us on your regular mailing list to receive *Inventory?*

L. Lewandowski, M.D.
Buffalo, New York

Health Education Consultant

As the eastern area health education consultant for the State Board of Health, I am in need of up-to-date literature, especially pertaining to alcoholism. This need is heightened by the fact that I am also serving as health education consultant in the State Migrant Project. Will you please send me *Inventory?*

Miss Elizabeth Berryhill
Greenville, N. C.

VOL. 19, NO. 3 INVENTORY 1970
ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

An Industrial Alcoholism Program and how it developed

BY GRAY WHEELER, SR.

The program didn't "just happen; it came about as the result of long-range planning, cooperation and a mutual need for each other by the parties involved."

The Alcohol Information Division of the Neuse Clinic, New Bern, N. C. has had the good fortune to help establish and make operational a complete "Industrial Alcohol Rehabilitation Program" within a specific industrial complex involving a sizable work force. The industrial unit involved is the Naval Air Rework Facility (N.A.R.F.) at the Cherry Point Marine Corp Air Station, Cherry Point, North Carolina.

N.A.R.F. employs an average of about 2,700 civilian employees who are Federal Civil Service workers and function under the supervision of the Department of the Navy. Their principal duties are the maintenance, repair and overhaul of Navy and Marine aircraft. Most of the employees are skilled and semi-skilled artisans, and the average yearly payroll is about 27 million dollars. This is the largest industry in Eastern North Carolina, and practically 100 per cent of its employees live within the four county (Craven, Carteret, Jones and Pamlico) catchment area served by the Neuse Clinic, a facility operated by the local mental health authority in partnership with the State Department of Mental Health.

The services being rendered N.A.R.F. by the Neuse Clinic did not, as the saying goes, "just happen." They came about as the result of long-range planning, cooperation, and a mutual need for each other by the parties involved. Briefly, the program came about as follows:

In the fall of 1967, Gray Wheeler, Sr. who was, at that time, director of the Alcohol Information Center, New Bern, N. C. contacted Dr. Norbert L. Kelly, director of the Division of Education, N. C. Department of Mental Health, to ask his advice on

how to inform N.A.R.F. and their employees with a drinking problem about the services available to them through the Alcohol Information Center in New Bern.

Dr. Kelly and Mr. Wheeler shortly thereafter conducted a one-day workshop for general supervisory personnel at N.A.R.F. Pertinent, basic information was presented at that time. Health problems connected with alcohol and alcoholism and the problems that industry suffers from them, as well as some of the remedies available, were outlined. As a result of this groundwork, Dr. Kelly and Mr. Wheeler got a "foot in the door," so to speak.

In March of 1968, N.A.R.F. asked Mr. Wheeler to conduct a more extensive workshop for their supervisory personnel. By this time the Alcohol Information Center had been incorporated into the Neuse Mental Health and Alcoholism Center as its Division on Alcoholism. Consequently eight two-hour sessions over a period of eight weeks were conducted at N.A.R.F. In this endeavor, Mr. Wheeler had the help of Alcoholics Anonymous members, a Navy doctor, a minister and the education director and industrial program director of the division.

Several roadblocks to significant progress became apparent during these training sessions which were conducted during April and May of 1968. Attendance, being voluntary, was small on the part of the supervisors. There was no "company" doctor to whom suspected alcoholic employees could be referred; and the union was in the process of organizing the workers at the facility. It can be said, however, that gains previously made were consolidated. In other words, the foot got "a little further in the door."

In November of 1969, N.A.R.F. again contacted Mr. Wheeler and asked for immediate assistance. The facility was caught in a cost-production squeeze and had fears of being phased out as part of the Federal Government's economy drive.

In response, Mr. Wheeler and his industrial program director met with the Military Commander of N.A.R.F. at his request and in his office at the base. Also attending the meeting were the head of civilian personnel, the chief union steward (the union had been voted in and was now operational), a full time company doctor (a civilian well trained in alcoholism), and all other top management representatives located within the facility.

Navy Bulletin Is Impetus

A bulletin from the Department of the Navy that officially recognized alcoholism as a health problem (the only Government agency at that time which had done so) was discussed at this meeting. The concensus was that N.A.R.F. "had a problem" and that all the "powers" present wanted the assistance of the Neuse Mental Health and Alcoholism Center in helping them set up an industrial program to combat problem drinking.

Out of this meeting came the nucleus of authority and assistance from N.A.R.F. that the Neuse Mental Health and Alcoholism Center had to have in order to use its know-how to get an on-going program started. N.A.R.F.'s first request was that a counseling service for the already known and admitted problem drinkers be started. N.A.R.F. provided an office across the hall from the company doctor and counseling hours were set up for each Tuesday afternoon from one to four o'clock. The counselor was to be provided by the Neuse Mental Health and Alcoholism Center, and the employees were to be seen on "company time" with no loss of pay. This counseling service still exists at the same hours.

Shortly after January 1, 1970, the commanding officer sent out a directive advising all employees of the Department of the Navy's policy toward problem drinkers and of N.A.R.F.'s policy. All supervisors were put on a roster to attend training sessions of alcohol and alcoholism and their connection with industry in particular.

The schedule for these training sessions was worked out by the N.A.R.F. training supervisor and the staff of the Neuse Mental Health and Alcoholism Center who were to conduct the sessions. In the final working arrangements, it happened that all supervisors *had* to attend, ten two-hour training sessions were conducted over a period of two weeks, and about twenty supervisors attended each session. One make up session was held for absences caused by sickness, shift changes, etc.

The training sessions were thorough in their treatment of the subjects of alcohol, alcoholism and, particularly, their application to problem drinkers in industry. "Need for Decision," an excellent film made for Union Carbide Corporation, was used. The supervisors were well schooled in the use of "motivational tools" and "ways to spot the problem drinker" as early as possible, as outlined in the "supervisory Guide on Alcoholism" of the Department of the Navy. Also, they were taught a method of recording pertinent information on suspected problem drinkers that would be useful to the company doctor in making a diagnosis of alcoholism when it was thought to be present.

In the actual operation of the program, the company doctor, after making a diagnosis of alcoholism, then escorts the employee across the hall to the alcoholism counselor's office if he believes his help is needed. Three possibilities of referral for inpatient treatment are open to the alcoholism counselor. He can refer cases of acute alcoholism to the Craven County Hospital, one of the few public hospitals in the state that admits patients under the diagnosis of alcoholism; or to the Alcoholism Unit at Cherry Hospital, Goldsboro, a state hospital for treatment of the mentally ill. Non-acute cases that otherwise meet the admission requirements can be referred to the Walter B. Jones Alcholic Rehabilitation Center at Greenville, a regional treatment facility operated by the Department of Mental Health. The Department of the Navy will allow thirty days leave for treatment in accepted and accredited institutions.

As far as outpatient treatment is concerned, there are a number of A.A. groups in the area, the Neuse Clinic which has a full-time psychiatrist as director, and the usual community agency and church resources.

In addition to the initial impetus and leadership that Dr. Kelly and Mr. Wheeler gave to this program, a series of happenings and their consequences followed that contributed greatly to the program's workability. Essentially, they were:

1) The endorsement of and request for this program came from both "top" management and labor.

2) Supervisory employees received *enforced* and *adequate* training from alcoholism counselors and other personnel knowledgeable in industrial alcoholism programs.

3) There was mutual cooperation between a company doctor who was knowledgeable about alcoholism and informed supervisors and alcoholism counselors.

4) The counseling service was adequate and had dependable back up resources for referrals.

5) Company and union policy allowed time for rehabilitation and adjustment by problem drinking employees.

(Continued on Page 31)

An Alcoholic's View of SOCIETY'S ROLE

BY A FORMER PATIENT
OF
CHERRY HOSPITAL
GOLDSBORO, N. C.

"Too often the alcoholic sobers up to find that he is as much alone with his problem of trying to stay sober as he was with his problem of getting drunk."

There are several theories pertaining to the causes of alcoholism, ranging from heredity to environmental conditions, to varying degrees of mental disorder, to a bodily chemical imbalance, ad infinitum. Any one, all, or none of these possible causes may be applicable to a given individual. However, when the disease has reached the chronic stage, the behavioral pattern of the individual usual follows a definite course.

The major thing that is known about the disease of alcoholism is the social aspect—the social repercussions, the hardship, sorrow, heartbreak, deprivation and degradation that is inflicted not only on the victim but on his family and on society in general. The terminology, *alcoholism*, is itself a social definition derived from the name of the substance that brings on the disease. So far there is no medical term to identify the disease.

Not being qualified to give an opinion on the "why" of alcoholism, I will not attempt to explore this area, medically speaking, at any rate. My area of exploration will be confined to a discussion of certain symptoms that have been observed and the so-called "alcoholic thinking" that is usually present when the disease has reached the chronic stage. On these subjects I am qualified by experience to share my beliefs and feelings as well as my opinion of some societal factors that contributed to them.

While the victims of other diseases, such as heart, kidney, diabetes, and allergies, are often prone to embellish and exaggerate their symptoms as well as the discomfort and inconvenience of their illness, the tendency of the vast majority of chronic alcoholics is to minimize the seriousness of their illness. Why so different?

I believe that this tendency to minimize is due in large part to the fact that we attach a certain amount of shame and guilt to our disease and it thus becomes a moral issue with us. We feel to a degree that our illness is self-inflicted, and we have the certain knowledge that this opinion is shared by the vast majority of society. We have heard for a long time that

our becoming alcoholics is the result of our lack of will power, character weaknesses, and inability to cope with the rigors of life. In short, we have been told that we lack the essential attributes of manly behavior and therefore succumb to some basic weakness that results in our losing control not only of our drinking habits, but in all areas of life. It is my belief that this line of thinking contributes greatly to our shame and guilt, and is one of the primary reasons for our minimizing the severity of our illness.

By the time we reach the stage of chronic alcoholism, we have reflected

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on our own past feelings toward alcoholics, more often referred to as drunks, and recalled their apparent concern only for self, their irresponsible behavior toward their families, and the many other insidious manifestations of their condition. We have remembered that we looked upon these people with far less than tolerance, compassion and understanding. We were critical of them, feeling that they "brought it on themselves."

And here we run into a real hang-up! When we finally come to realize our alcoholism, we either consciously or subconsciously exercise this same attitude toward ourselves. Our attachment of shame and guilt to our disease in this way makes it extremely difficult for us to admit and accept the seriousness of our illness and we will, as long as is physically possible, minimize it. This, I feel, is one of the greatest deterrents to our arriving at a point where we can even begin a plan of treatment to arrest the progressive symptoms common to alcoholism.

During the chronic stage of our illness, the things we most often hear from professional people are the dire, pathological effects of alcohol on our bodies—physical destruction, irreparable brain damage—and their eventualities of insanity or the drunkard's grave. Though based on sound medical knowledge, this is sometimes called the scare approach which, in the vast majority of cases, proves fruitless. We alcoholics can perhaps be scared into sobriety temporarily, but not permanently.

From the social point of view, the attitude we get from our friends and our families is "what we are doing, not only to ourselves but to them and society in general." This attitude, while justifiable in the light of our behavior, tends to put us in the freakish category of "carying only about ourselves and our own personal wants which are pretty much limited to the bottle." To get our bottle, supposedly, we will literally do anything!

It is constantly being drummed into us that our condition is affecting the lives of all those around us, and the responsibility of doing something about it is placed squarely on our shoulders. At this point, in the hope of "waking us up," of stirring us to the point of doing something about our problem drinking, the guilt approach is often brought to bear. We are appealed to through our sense of what is right and wrong. We are told that our behavior is sinful; that we are irresponsible drunks. These are labels that strike directly at our ego, and are difficult for us to accept.

Again, this is a contrast to what we'd be told if we had some other disease. If we were victimized by cancer or heart disease, society would not place the responsibility of succumbing to the disease on us and

then leave it to us to do something about it.

These attitudes toward our illness are, to a large extent, the result of misinformation, not only on our own part, but by society in general.

While it may appear that we have performed willful acts that have brought on our illness, such is not the case. I do not believe that anyone, alcoholic or nonalcoholic, who has ever partaken of an alcoholic beverage started out with the intention or desire to become an alcoholic. None of us that it happened to had the remotest notion that we were embarking on a road that would lead to self-destruction when we took our first drink for whatever reason—sociability, inferiority complex, wanting to be one of the crowd or as a mark of manhood.

As our alcoholism progressed, we came to realize that our lives were becoming unmanageable, but we did not relate our problems to alcohol. Everyone else did, but we could not accept and admit this simple fact. When we finally, usually at a much later date, began to entertain the idea that alcohol might be a part of our problem, our sense of judgment and reasoning had become so impaired that it was impossible for us to sustain a mental attitude towards solving our problem for a long enough period for us to execute any plan of recovery.

It is often at this stage that somewhere deep in our subsconscious an indescribable fear takes over. We won't admit that we are harboring this fear, but it starts to dominate our lives. Outwardly we give all the signs of bravado, trying desperately to impress others that we have the situation well in hand, that there is nothing to be concerned about but, nevertheless, the nameless fear is making inroads into the very heart of our being. I believe many of us refuse to admit these things because of the guilt and shame we associate with alcoholism.

Having arrived at the stage of indefinable fear, we have exhausted every possible avenue of blame for our problem drinking and now, to avoid admitting total and final defeat, we decide that a solution to our problem may be to change our drinking pattern. We decide to drink only on certain occasions or during certain hours or to change our brand or to switch to drinking only beer or wine or cognac. But in time all these efforts fail to bring our drinking into moderate bounds. We are ignominiously defeated.

Dreaded Remorse

Now comes the most dreaded and excruciating of emotions, remorse. We realize that all "they" have been saying is true. We have let ourselves be reduced to a shell of a man. We have become chronic liars, totally irresponsible, undependable, unreliable and untrustworthy. We also realize, deep down, that we are chronic alcoholics. However, the term that we are most likely to apply to ourselves is "hopeless drunk."

At this exact and critical time we more than ever desperately need understanding and compassion coupled with the help and guidance of knowledgeable people who have a first hand understanding of our disease. The most likely person to fill this need is a recovered alcoholic. Drawing on his own experience, he can often reach the suffering alcoholic when all others have failed. In many cases the individual will need medical help and possibly a period of confinement in order for him to attain a mental, emotional and physical state whereby a plan of recovery will at least have a possibility of succeeding.

Without this kind of help at this crucial point, the sufferer will be driven further and further into his "box"

with accusations, deprecations and "I told you so." As the box becomes tighter and tighter, the door out becomes smaller and smaller. Eventually we alcoholics close this door ourselves in self defense out of a desire to just remain alive. We close the door with our liquor bottles inside because now this is the only solace we have left. To our deranged minds, the bottle is our sole source of comfort, the only thing left with any element of understanding. This comfort is short lived, of course, for even in our alcoholic state we soon come to realize that this temporary haven dissolves into a monstrous nightmare.

Then we sit in this box totally encompassed in self-pity. What "they" have told us for so long, what we have come to realize through the nameless fear, has proven to be true. We have fought gallantly, tried desperately to prove them wrong, but now there is no longer any fight left in us. Long ago we stopped caring about anyone or anything else. Now we no longer care about ourselves.

Let us assume for purposes of this discussion that by one means or another we temporarily get rescued from our box. We get dried out, possibly in a hospital or a jail. Perhaps a friend, if we have one left, nurses us back to reasonable sobriety. We gradually get back a partial sense of reasoning. We get over the shakes. We get built back up physically. Then we are faced with another crisis.

If, at this point, the individual becomes ready to *accept* the fact that he is totally powerless over alcohol (earlier he had *admitted*, now he must *accept*), and he *wants* to do something about it, his chances of recovery are very good. However, it is vitally important that he be given some tools with which to initiate a program of recovery. Such help can come from a friend, a doctor, a minister, a member of Alcoholics Anonymous, anyone who will help him with a realistic approach to a plan of recovery.

Unfortunately, the extent of the knowledge of the victim and the people around him is too often limited to the unenlightened conclusion that his alcoholism is the result of his wrong doing; that the shameful behavior that he has perpetrated over a period of years has resulted in his present condition. He must now turn around, he is told, and follow the straight and narrow path; he must grow up and start acting like a man and become a responsible individual. He is admonished by well-meaning family and friends to stop his sinful ways and to start walking in the light. They remind him that they have been instrumental in getting him sober and that now it is up to him. There is nothing they can do.

And so, overcome by a sense of shame and guilt, he vows to start a new life, to never take another drink, and he means it. Bear in mind that he embarks on this new way of life armed with only one tool—the determination to never drink again. He often gets daily "help" from friends and family in the form of reminders of his past and where it has led him. These reminders are well-intentioned and meant to help him to renew daily his determination to *never* drink again. He is also constantly reminded that "no one can do it for him, he must do it alone." This kind of help will lead straight to his total and irretrievable destruction.

It is an irrefutable fact that few alcoholics have ever recovered alone. The only thing he can and must do alone (with God's help), is to make a decision to *want* to do something about his illness. Other than that he needs all the supportive help and insight into his problem that he can possibly get. He needs boundless help, not only from his fellow man but from God. If he knows no God, he needs

help in finding a God that he can understand. Too often the only God he knows is a God of retribution who will sentence him to hell for his sins. He has passed the point of thinking of Him as a friend who will help him through his hour of need. The fear of losing his family, his job, his very life and soul may keep him sober for a period of time, but it will prove as transient as the solace he once found in the bottle.

Without help, he takes his fear, shame, guilt and determination never to drink again into the new sober life he is to pursue. As he walks down the street, clothed in his insecurity, he is certain that everyone is looking at him, looking down at him, saying to themselves, "There goes that sorry drunk. Look what he has done to himself. Look what he has done to his family. He could have been this or that or the other." He puts up a fight and stays dry for days, weeks or months. He is sober, but he is miserable. Without anyone to help him understand the true nature of his illness, he inevitably succumbs to the shame, guilt and finally self-pity he feels and the cycle begins all over again. He returns to the source of his temporary relief. He knows that it will lead him back into his box, but this does not deter him.

Too often the alcoholic sobers up to find that he is as much alone with his problem of trying to stay sober as he was with his problem of getting drunk. As people continue to tell him that he must lick his problem alone, the loneliness that became unbearable when he was drinking continues to persist while he is sober. In this destructive atmosphere and environment, the sober life appears no better and, in some cases worse, than the drunken life.

Bear in mind that little has changed other than his not taking a drink. He has been told over and over again that his problem would be solved if only he would stop drinking, but it isn't working out that way. The same emotional conditions that drove him deep into the bottle—fear, remorse, guilt, shame, doubt, lack of faith, distrust—are still present. He has repeatedly been told that his drinking is affecting the lives of countless others and, in the same breath, that only he can do something about it. This line of reasoning is incongruous. Do not the people whose lives are so closely entwined with the victim have a role to play in this recovery? Are they not unwittingly contributing to the perpetuation of these destructive emotions?

The alternative to returning to the drinking cycle for the alcoholic at this point in the crisis is for him to be surrounded in an atmosphere of understanding and compassion. He needs the counsel of knowledgeable people who can help him toward a better insight into his illness. He needs help in alleviating the pressures of the shame, guilt, fear and to be brought to an awareness that he is no longer alone; he does not have to slay this monster alone as he has so often been told. The past must be put in perspective, and he must be assured that he has supportive help in facing the future lest the fear of failing again overtake him.

One good source of supportive help is Alcoholics Anonymous. Surrounded by recovering alcoholics, he begins to overcome the fears and doubts about being able to stay sober. His shame and guilt is lessened when he begins to realize that he is no worse than many others. He no longer feels like a freak; he belongs and he is loved. In this fellowship, he takes his first step back into society from which he felt ostracized. He regains some degree of self-respect and self-confidence. He gradually comes to

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How Does a Program Measure Success?

"Tell me what success is in alcoholism treatment and I'll tell you how successful we are."

BY JOHN SALTMAN

DIRECTOR
SOUTHWEST WASHINGTON
ALCOHOLIC RECOVERY FOUNDATION
VANCOUVER, WASHINGTON

"What is your success ratio?" The question is nearly as persistent for the director of an alcoholism treatment center as "What is your batting average?" for a baseball player. It is sometimes asked skeptically, sometimes hopefully, sometimes despairingly. The query comes from prospective patients, doubtful M.D.'s, spouses at their wits' end, and reporters looking for a story. The most appropriate answer is "Tell me what success is in alcoholism treatment and I'll tell you how successful we are." It sounds like a parry, but it is an appeal for help. Standards of success in combatting alcoholism are largely lacking.

In simplest terms, the goal of treatment could be described as immediate, complete, lasting sobriety.

How long is lasting? The spouse of a patient in treatment wrote to say that the marriage could be resumed if he could prove that he would never drink again. He said sadly, "I could only do that by dying . . . then they could say, 'good fellow, he never drank again'."

For some illnesses there is a commonly-accepted time period after which it is agreed that the illness is cured or arrested—one, three, or five years. Not so alcoholism. What does lasting mean?

Must sobriety be immediate to rate as a success for a treatment program? A not uncommon pattern for alcoholics leaving an in-patient facility is a period of sobriety followed by a "slip." The drinking episode may be brief or extended, mild or severe. While for some it is the resumption of the habitual pattern, for others the "slip" serves to clinch the lessons learned in treatment. Critics of the program, observing the drinking episode, see it as evidence of failure. Is it? How essential to success is immediate recovery?

Is complete sobriety the only result which could be called successful? This question is influenced by the prevalent doctrine that the recovering alcoholic can never drink again, which if not 100% true is lacking documented

Reprinted from **Focus** a publication of the Washington State Department of Health.

evidence of exceptions. It is one thing to affirm that the alcoholic can never become a moderate drinker—which we do affirm. It is another thing to say that an occasional drinking episode after treatment means that the treatment failed. Comparing previous performance with the occasional drinking may indicate that it was hugely successful. Consider the individual who has been drinking daily or weekly for years. He has become unable to face the pain of his life—even the smaller burdens — without large amounts of alcohol. Then, undergoing treatment, he becomes able to handle most crises without drinking. He holds a job, restores his family, yet, on rare occasions something happens which he cannot handle—and he resorts to the bottle. The episode causes him grief, but he resumes sobriety—perhaps with help from the treatment source. This person was once 90% victim of his alcoholism. Now he is 10% victim. Yet his sobriety isn't complete. Did the treatment fail or succeed? Was it worthwhile for him and the treatment facility to invest dollars and days in the program, even though the result was not, in traditional terms, complete recovery?

Society is, in general, less charitable concerning alcoholism treatment than treatment for other illnesses. If a critically-ill heart patient had an operation and, as a result, had one year of useful life before the disease recurred, would anyone call the operation a wasteful falure? Yet those who are treated, maintain sobriety for a year and drink again, are cited as evidence of being inadequately treated.

It is apparent that although the goal of treatment is immediate, complete, and lasting sobriety, we cannot measure our work by such a scale. How, then, shall we judge the effectiveness of treatment?

There are some inadequate responses to that question. One is the refusal to measure effectiveness. It is my impression that this is fairly prevalent among treatment agencies. In visiting a prestigious nationally-known center I inquired as to their rate of success — and more particularly their method of gathering information about their former patients. I was told that they have no system of followup and could offer no statistics. Something, at least, could be said for this position—it saves prevarication! This is a little like gasoline mileage with your car—the only two ways to be happy about it are not to keep track, or to lie about it.

Treatment people who say, "We don't (or more frequently, we can't) publish reports on our results" can be frank, honest and even unctious as they state that the anonymity of their clients precludes following them once they leave.

The Safe Procedure of Estimating

Another response to the inquiry about effectiveness is to estimate. This is also a safe procedure—if one is careful with his language. Never say "We achieve blank percent success," but "We estimate blank percent success." After all, everyone has the right to estimate. The fact is that there may be precious little relation between the estimate and the real situation. As the director of a treatment program I am in a good position to estimate. On some days, when word has filtered through that one or several of our graduates are failing spectacularly, I would estimate that we ought to quit the business as promptly and gracefully as possible. There are other days when good word comes and we talk enthusiastically of our achievements. At such times even 75% doesn't sound too high.

Another approach to the question of success is to gather what information is at hand about former patients and extrapolate to cover the rest. In my

travels to a number of treatment centers during the past year I asked one staff member of an institution which treats several hundred patients a year —and issues rather detailed reports giving the number sober, those drinking, those drinking with some sobriety, etc.—just how they gather such information. He replied that it was done principally by the grapevine. Apparently someone totaled up the number reported drinking, the number sober, figured the ratio, multiplied it by the total treated and presto, instant statistics.

With all due credit to the grapevine as a source of facilitating tidbits, our experiene tells us that it is highly unreliable. There is good reason for this failing. Hardly anyone around the recovering alcoholic is able to be clinical. Some are pulling for him with all their might—and are loathe to entertain the thought that he is drinking again. Others are watching with jaundiced eye, sure that he will fail and very quick to celebrate even the faintest suggestion that he has slipped by picking up the phone to tell someone.

The situation is pregnant with inaccuracy. I know—for I have tried that game too. Reports via hearsay or secondhand information are often contradicted by the next word to come down the vine. We tend to remember the favorable word and forget the unfavorable. The all-too-prejudiced gatherer of this information (in this case the treatment director who is so eager for the success of his patients) is in no frame of mind to sift the news dispassionately. To put it bluntly, such statistical reporting is hokum and humbug.

This is the situation. For lack of standards of measurement, and without responsible means of gathering information, alcoholism treatment is devoid of an indispensable ingredient of therapeutic program—continuing

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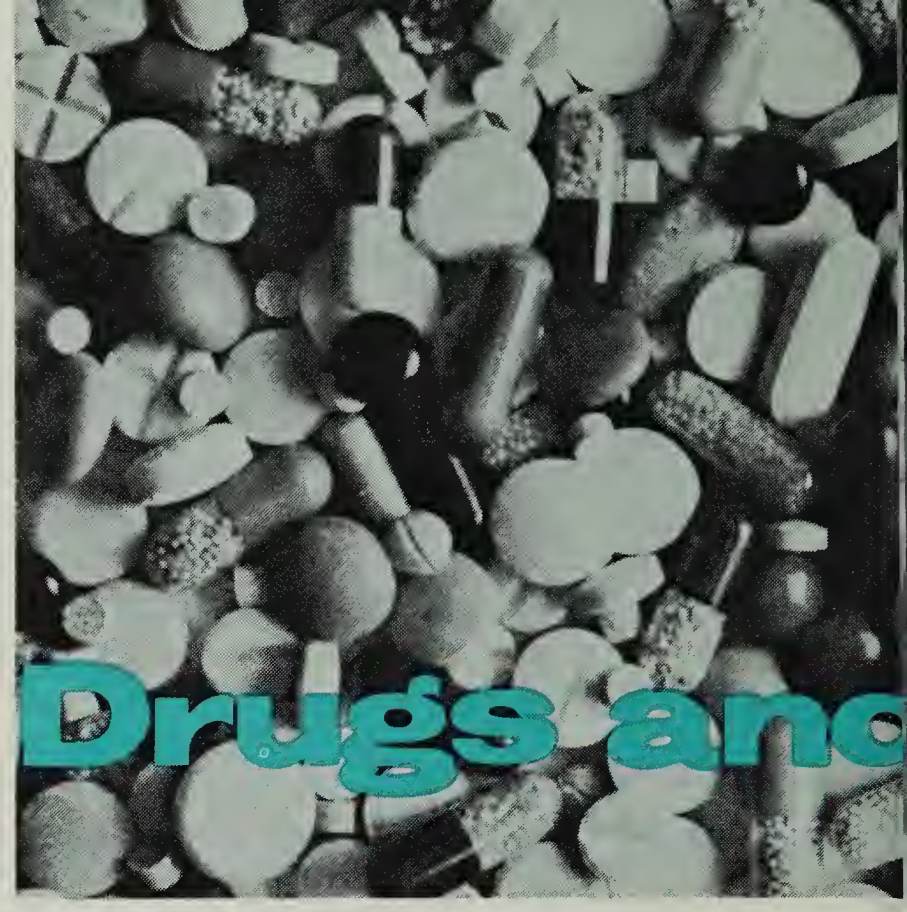
AN ALCOHOLIC'S VIEW

(CONTINUED FROM PAGE 12)

realize, almost imperceptibly, that he has rejoined the human race. What had at one time seemed an unattainable feat was happening. What had he contributed to the attainment of this new state of well being? He had abstained from drinking alcohol, but this is far from being the only factor involved. Without the alleviation of his feelings of guilt and shame, coupled with fear and aloneness, his chances of recovery would be practically nil. These things he cannot accomplish alone.

There is no more dangerous and erroneous belief that he must "do it himself." Many people play many different roles in his recovery. It is often said that as our alcoholism progresses we become like little children. Without the proper balance of love, understanding, compassion and discipline, a child has little chance of maturing into a happy, healthy, productive human being. We are truly like children, and until we can replace fear with love, guilt and shame with compassion, loneliness with understanding, and indulgence with discipline, we will regress to the stage of being helpless infants.

I do not mean to minimize in any way the responsibility of the individual in his own recovery. He has the gravest responsibility of all—that of admitting and accepting his condition. Without this first step, all other efforts may be in vain. But once he has taken this step, the whole of society —including the father, the mother, the husband, the wife, the employer, the friend and society in general—must accept their responsibility and perform their proper role in the recovery. Until we have such an alcoholism oriented society, progress will be slow and chances of recovery for the alcoholic will remain slim.



Whenever as much emotional controversy surrounds a topic as surrounds that of drugs it should suggest that we reexamine the problem and the words we use in talking about it. "The drug problem" is complex. It exists for most people at the level of feeling, opinion and belief. These feelings and beliefs color our perception of the problem and the meanings of the words with which we discuss it. Much of the current misunderstanding and controversy arises because of the great variety of implicit assumptions lurking behind every term we use.

The first requirement of either wise personal decision or informed social action is full awareness of all that is involved in that decision or action. We need the best available knowledge about what drugs are and how they act, not uninformed opinion and belief. We need to be aware of what we do not know and to beware of substituting opinion and belief for ignorance, sometimes recognizing that what we do not know can be more important than what we do know.

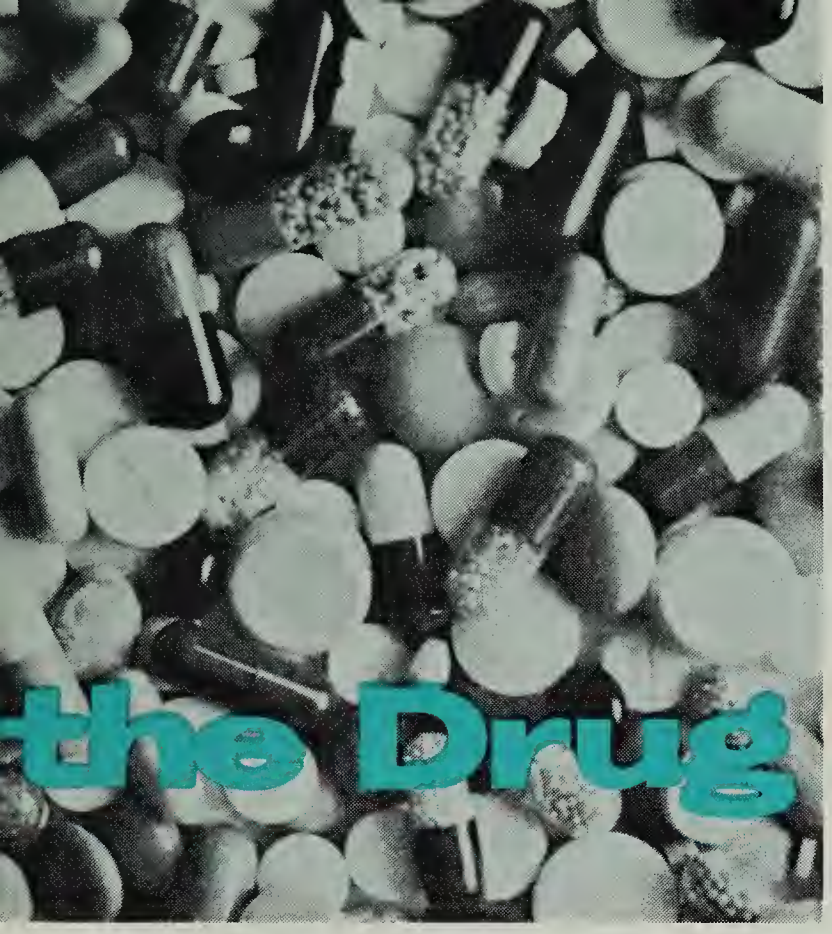
We need to recognize that the problem is not drugs as pharmacological agents; the problem is people. It is a personal problem, a social problem, a political problem not only of people who use certain drugs but of people who make judgments about drugs and about people who use those drugs. We need to distinguish between use and abuse. We need to explore the variety of meanings and functions of drug use, all drug use.

We have a model in our national drug—alcohol—but we refuse to label alcohol a drug and refuse to learn from our experience with it. It is a drug in very sense except social definition. It acts according to the same principles by which every drug acts. Alcohol use serves many of the same functions and involves many of the same risks.

If we temporarily put aside our value judgments about drugs and about people who use drugs and assess the present state of our knowledge about drugs and drug use, we may be better able to return to these value judgments—which are the core of the problem—better equipped to deal with them.

To many people drugs are magic potions. If they are "good" drugs they can do no harm. "Good" is defined as safe and effective in the treatment and control of disease or pain. We call these drugs "medicine." If they are "bad" drugs they can do no good. "Bad" is defined as dangerous and used for purposes other than the treatment and cure of disease or pain. We call these "narcotics," even though the majority of them are not narcotic in a pharmacological or medical sense. A narcotic is a substance which in sufficient amount produces sleep and stupor and relieves pain.

So we end up with some curious situations. If a phenobarbital or an amphetamine is prescribed by a physician it is medicine and safe; if it is not prescribed by a physician it is a "narcotic" and dangerous. There are hazards in both assumptions. Virtually all drugs are dangerous—whether we call them good or bad, medicine or



the Drug Problem

"The real drug problem is learning to live wisely in our increasingly chemically dominated society . . ."

BY HELEN H. NOWLIS

narcotic. But the danger is not a magic property of the drug. It is a function of many factors, not the least of which is why and how the person who takes the drug takes it.

In order to think clearly and rationally about drugs, all drugs, we need a definition of "drug" that does not have in it a host of implicit assumptions and value judgments. Assumptions and judgments are necessary but they should be based on facts and not beliefs. We need an objective and descriptive definition that makes no assumptions about the accepted or unaccepted uses of a drug or about the good or bad effects.

The basic pharmacological and biochemical definition meets these requirements. According to this definition *a drug is any substance which by its chemical nature affects the structure or function of the living organism*. This definition includes a wide range of substances, much wider than most people are comfortable in considering or most professional groups consider useful. It will, however, provide a context and a perspective within which any group of substances must be viewed if we are to plan wise and effective individual and social action. It will also enable us to put aside, for the moment at least, conflicting attitudes, opinions and beliefs, and to start thinking about this problem on the basis of what we know about how these substances interact with the living organism.

We are living in an environment increasingly dominated by chemicals. These include not only an increasing number of medicines and "narcotics" but an increasing variety of substances which, in our wisdom, we prefer to call beverages, cigarettes, food additives and preservatives, agricultural and industrial chemicals, household chemicals, pollutants, even food. Virtually all of these interact to some degree with the living organism. The real *drug* problem is learning to live wisely in this environment. Basic to any wisdom is an understanding that in the case of ingesting, inhaling, injecting *any* of these substances we are essentially adding chemicals to the complex, delicately balanced, and as yet little understood biochemical system that is the living organism. A high school chemistry student knows he must not add a known substance to

Reprinted by permission from Vol. 2, No. 2, Oct. 1, 1969 issue of *engage*, published by the Board of Christian Social Concerns of the United Methodist Church. Dr. Nowlis is president of the National Coordinating Council for Drug Abuse Education and a member of the faculty of the University of Rochester School of Psychology, Rochester, N. Y.

a complex unknown or partially known solution.

What do we know about this system to which we are adding chemical substances? It varies from individual to individual and from time to time in the same individual. It varies with apparently inherited biochemical characteristics. It varies with age. It varies in sickness and in health. The "effects" of adding chemicals to it are incompletely determined. Response to each is really a numbers game in which the odds in favor of any given response are relatively high for some and relatively low for others.

Response to Drugs Varies

Above all, the response to any drug is a function of the amount of dosage level. For every drug there is an "effective" dose, that amount which produces in a plurality of individuals whatever one is seeking, in addition to a lot of other things. This varies from person to person and from effect to effect. For most drugs there is a "toxic" dose, that amount which produces in a plurality of individuals whatever one defines as toxic. For most drugs there is a "lethal" dose, that amount which produces death in a plurality of individuals. The amount that is "toxic" or "lethal" in a single, acute dose may be "effective" if administered over a period of time.

The pharmacological properties and the amount of a drug are only two of the many factors that determine response to a drug. The route and speed of administration are very important. The difference between slow absorption through the digestive system and injection directly into the blood stream through a vein is dramatic. The pattern of use is important. Effects of frequent use or long term chronic use may be very different from a single administration.

We have already mentioned the physiological characteristics and current physiological state of the individual. One has only to read the "contraindications" or "warnings" on any bottle or in any pharmaceutical ad to recognize the importance of these factors.

When we move to the behavioral or subjective responses to drugs, the picture becomes even more complex, especially in organisms with a language and a culture. In many instances the most important factors are the reasons why an individual uses the drug, what he expects the "effects" will be and how he responds to or interprets the effects he perceives. This factor is so important that in many instances the individual will experience the effects he seeks or expects even when a pharmacologically inactive substance is substituted for the drug. Particularly in the case of some primarily psychoactive drugs, some individuals do not experience the "effects" of dosages that produce recognizable effects in experienced users who have strong expectations. Up to one-half of those who try marijuana do not get "high."

In a recent experiment amounts of marijuana, which regularly produced a "high" in experienced users, did not produce a "high" in naive subjects even when the dose was high enough to produce observable physiological reactions. Important, also, is the meaning of perceived effects to the individual and the way he thinks of himself and his relationships to the physical and social environment. Changes in perceptions of the environment may cause panic in an individual who is comfortable only when he can predict and control, but be an interesting new experience for one who seeks or enjoys new experiences. Even the fact that the drug is illegal and that possession is a felony can add to the "effect" an element of paranoia, guilt or anxiety.

To an increasing number of peo-

ple who have worked with drugs, and with people who use drugs, all of this suggests that studying the reasons for, and the meaning and the significance of, the decision to use (and especially to continue using) drugs is far more fruitful than studying the "effects" of drugs in the laboratory. There any good scientist will eliminate or randomize the multitude of non-drug factors which are extremely important in determining the effects of drug use. It is becoming increasingly evident that the agent of abuse or addiction can be any of a variety of substances—opiates, alcohol, barbiturates, cigarettes, even food. When one agent is unavailable another may be substituted which has serious implications for dealing with drug abuse.

What is Drug Abuse?

Not only must we revise our concept of drug and drug effect in line with modern scientific knowledge, but we must refine our concept of drug abuse or at least be very clear as to how we are defining it. One of the central problems contributing to emotion, controversy and lack of effective action relating to the current "drug problem" is our definition, or rather lack of clear definition, of abuse.

Socially and legally the definition of abuse is any use of a substance that has not been accepted by the medical profession as being useful in the treatment of medically defined illness, or the use of medically approved substances for non-medically approved reasons or without medical supervision, *provided the substance has been labeled a drug*. This is the basis of our legal regulations; it is actually written into them.

If we have labeled the drug a beverage or call it by some other name, we have a completely different definition of abuse. In the case of alcohol, abuse is defined as a pattern of use that interferes with the personal, social, academic, or vocational functioning of a given individual. Approximately 70 per cent of the adult population of this country "use" alcohol at least occasionally; only a fraction of these are considered to abuse it.

Once we attach the label "abuse" we invoke the image of extreme abuse and invoke the image of the physiolocally dependent heroin addict or the alcoholic, and often emotion rather than reason. This, combined with our persistent "magic-potion-notion" of drugs, leads us into social action, whether it be legislation, enforcement, education, or treatment, which has not been effective and may even contribute to the very problem we seek to solve. It also makes it extremely difficult for an individual to be aware of the meaning and significance of the decision to use or not to use on his growth and development as a person.

We do have a *drug* problem. It is a problem that permeates our society, young and old, ghetto and suburb, square and hip. It is the problem of learning to live wisely in our increasingly chemically dominated environment, of using wisely and intelligently the products of our technological society, of understanding that we cannot continue to assault indiscriminately, with an increasing number and variety of substances, an organism that exceeds in complexity the bounds of man's imagination and we are only beginning to understand.

All drugs, whether we call them "narcotics" or "wonder drugs," involve risk. All are dangerous at some dosage in some people under some circumstances. As soon as we talk about risk we imply some benefit and whether or not the benefit is worth the risk. People decide what benefit is worth what risk. And people do not agree. As a society we believe that risk to cure illness is justified.

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BLACK MOUNTAIN—"The fact that industry is suffering very sizeable losses due to alcoholism has prompted us to make a concerted effort toward developing and implementing industrial alcoholism programs," Earl R. Anderson, alcoholism coordinator for the western region of the N. C. Department of Mental Health, reported. As a result of several planning meetings a seminar for top management—in the form of a banquet—is scheduled for September 17 at the Asheville-Biltmore Technical College.

The general managers of the three largest industries in the area—namely, Olin Mathieson Corporation, Champion Paper Company and American Enka—have helped generate interest in the seminar by writing personal letters to the top management of some 100 other companies within the region.

The principal speaker at the banquet will be Dr. Robert Raleigh who is the director of the Alcoholism Program of Tennessee Eastman Corporation at Kingsport, Tennessee, one of the three largest plants of the Eastman Company.

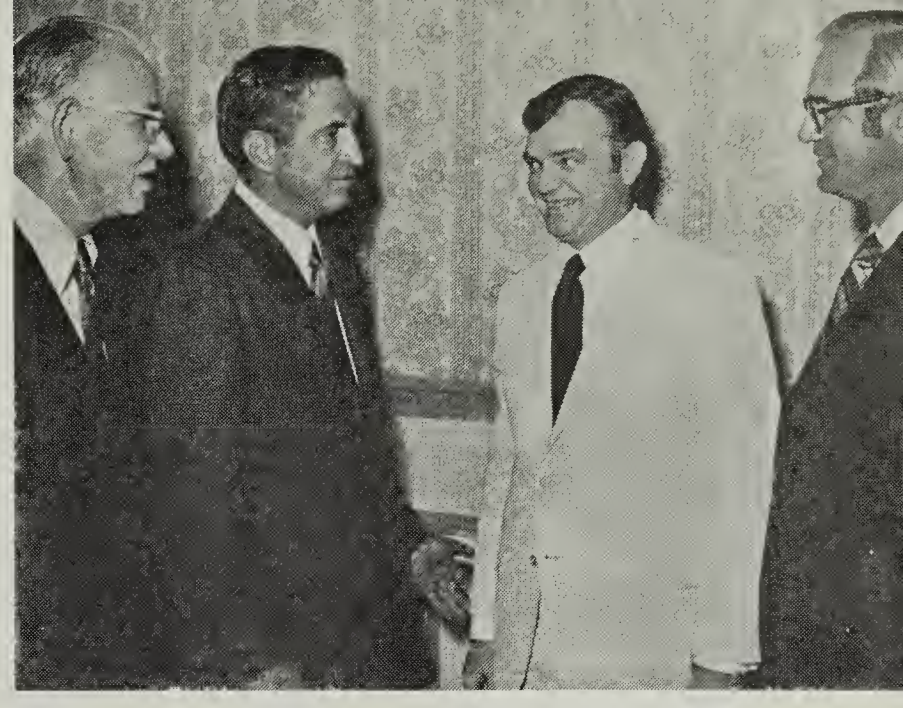
Further arrangements have been made with Asheville-Biltmore College to include a course on alcoholism in its "supervisors training" curriculum. This course will begin September 28 and will consist of weekly two-hour classes for six weeks. Its availability will be announced at the seminar, and Dr. Raleigh will conduct the first three classes. Hopefully, the course will be repeated at least four times a year.

These activities were preceded by a July workshop at the Alcoholic Rehabilitation Center at Black Mountain attended by 60 industrial nurses, and an August discussion with the Personnel Managers Association of Western North Carolina. The participants of the former demonstrated their interest by volunteering to participate in similar programs.

"In view of the high recovery rate (80 per cent on the average) reported by industrial programs," Anderson said, "we expect that the recovery rate at the ARC and community aftercare programs in the region will also become much higher as we manage to implement industrial alcoholism programs."

Summer School

Approximately 100 people attended the Western Region Summer School of Alcohol Studies conducted at Blue Ridge Assembly, Black Mountain, July 19-23. Every area in the region and the following disciplines were represented: sheriff's departments, vocational rehabilitation, departments of corrections and social service, nurses, teachers, social workers and mental health and alcohol information centers.



The Eastern Regional Summer School of Alcohol Studies conducted August 9-14 at East Carolina University was attended by 125 people. The participants represented 12 different disciplines and many of the region's mental health areas. Among them were legislators, mayors, county commissioners, doctors, ABC board chairmen, law enforcement officers, social workers, teachers and public health and county government workers. "I feel that we accomplished our objective which was to develop a network of alcoholism services for the alcoholic and his family," Howard Dawkins (right), regional alcoholism program coordinator, said. Shown with him are (left to right) Don Dancy, regional program director; Gus Hewlett, executive secretary of the North American Association of Alcoholism Programs; and Dr. John Gambill, clinical director of the Walter B. Jones Alcoholic Rehabilitation Center. Over 200 people attended the summer studies banquet at which this photo was taken by Greenville Reflector photographer Tommy Forrest . . . Elsewhere in the region, the Wilson Alcoholism Unit has arranged for a course on alcoholism and related problems to be conducted at Wilson Tech for Wilson County teachers. It will begin October 24 and meet each Thursday thereafter for 16 weeks. Also, the Onslow County Mental Health Center will have a 3-hour seminar for teachers on alcohol use and abuse November 25; and the Wayne County Mental Health Center is helping Kemp Industries develop an early detection and preventive alcoholism program for their supervisory personnel. Finally, a documentary of the Eastern Regional Alcoholism Program will be filmed by WITN Television Station during October to be presented to the public in March of 1971. Both the State Department of Mental Health, Division of Information and Public Relations, and the Jones ARC are assisting WITN in producing the documentary.

RALEIGH—The results and program recommendations of the one-year Regional Alcoholism Systems Project (RASP) of the south central region, Department of Mental Health, will be scrutinized by key groups soon prior to seeking implementing funds from the legislature.

On September 15 selected staff members from the Department of Mental Health system will evaluate the project and its results.

On September 23 RASP will inform the N. C. Consultants to the South Central Regional Alcoholism Program, a state-wide advisory group that resulted from the Governor's Conference last March, and seek their approval and support.

The next series of "tests" to be faced by RASP are approval by the Board of Mental Health, Advisory Budget Commission and, finally, an appropriation from the N. C. General Assembly for implementing expanded programs and new methods of operation.

BUTNER—All alcoholic patients, committed and voluntary, are admitted directly to the Alcoholic Rehabilitation Center here for evaluation and treated by the same staff under the direction of Dr. Norman A. Desrosiers. Dormitory "D", located at John Umstead Hospital, provides the necessary space. It is used mainly, though not exclusively, for patients who are "resisting" treatment in one way or another. The ARC serves the north central region of the Department of Mental Health and eight south central counties.

Out in the north central region, the Alcohol Information Center at Burlington, the Mental Health Center and the Technical Institute of Alamance County are co-sponsoring a course on "How to Deal with Alcoholism in Industry." The course will consist of six two-hour sessions held weekly. It will be aimed primarily at supervisors and line management employees, but some personnel workers will attend.

The essence of the "drug problem" and of the emotion and disagreement is not drugs but people, people who make value judgments, both pro and con, about people who do or do not use drugs. The opinions and attitudes and values involved in judgments about drugs are closely related to opinions and attitudes and values about many other things. They have to do with dependency and prejudice, with how one deals with problems, with pleasure and pain, with morality and one's concept of man, with law and the function of laws, with change and with increasing complexity. In our rapidly growing and pluralistic society there is increasing diversity in attitudes and values related to all of these. On the forefront of change are our young people.

Once we accept the facts that no drug is inherently good or bad, that good and bad often lie in the eye of the beholder, that there is no such thing as *the* effect of any drug, that drug effect is a complex interaction between a chemical substance and individuals who vary physiologically, psychologically, and socially, and that there is risk involved in all drug use—once we can accept these facts, we can begin to consider the broad implications of the physiological, personal, social, and legal risks involved in drug use in terms of the benefits or values served.

"We should not dismiss the reasons why people choose to use drugs. We should ask, 'Why?' We should look at drug use as a symptom, not of a disease, but of a need."

Automobiles involve risk. Guns involve risk. Alcohol use involves risk. Mountain climbing involves risks. Competitive sports involve risks. Exploring space involves risks. Society, or at least enough of it to pass or not to pass laws related to these activities, has made the decision that the benefits outweigh the risks and that it will, to varying degrees, merely try to reduce the risks. In the case of these activities there are some facts on which to base a risk-benefit analysis if we choose to use them.

In the case of drug use there is a growing body of facts, some of which are contrary to long-held beliefs, but not enough of them. Research is desperately needed, but research on the pharmacological properties of drugs or the physiological effects of large dosage levels in animals will not suffice. What is needed is research on drug use, on people who choose to use or not to use such substances despite "bad" effects, on the reasons why people make the choice they do, on the meaning and significance of either choice for an individual as a person. The absence of such research increases the risk factor in our risk-benefit analysis. What we do not know may hurt us.

Symptom of a Need

In the meantime we should not dismiss the reasons why people choose to use drugs. We should ask, "Why?" We should look at drug use as a symptom, not of a disease, but of a need.

The reason young people use legal drugs as well as illegal drugs are many—to relieve boredom; to have fun; to get "high;" to relieve fatigue, tension and anxiety; to find meaningful social relations; to solve personal problems; for self-exploration and understanding; even for religious experience. Adults use legal drugs for many of these same reasons. Illegal drugs have been widely "advertised" for all of these reasons.

That there are bad outcomes associated with some patterns of drug use in some people is freely admitted. These vary from the hangovers and

automobile accidents sometimes associated with alcohol use to the panic and arrest sometimes associated with use of marijuana and the increasing list of drugs against which we have legislated. That some people continue to use these drugs, despite bad experiences, testifies to the functions they serve, real or imagined.

Our society has long held that the only proper use of drugs, until such time as they escape from being considered drugs, is for the treatment of disease and the relief of pain and that all drug use should be supervised by or approved by the medical profession. There are segments of society which, for religious and philosophical reasons, do not accept even this use of drugs.

For a variety of reasons, which have not been systematically explored, but may include the advent in the early '50's of tranquilizers and antidepressant drugs and their wide use in the treatment of depression and anxiety of varying degrees, illness and pain have been redefined. We have almost accepted the fact that anxiety and depression are almost endemic in our society. Whether they are bad and to be relieved with drugs, whether they are uncomfortable but to be endured as strong motivating forces, or whether they are symptoms of the possibility that man—physically, psychologically, and socially defined—is not equipped to handle the conflicts, pressures, and pace of the complex technological society he has created is a matter of opinion and of a whole host of associated beliefs and values.

We seem to have accepted the necessity for an assist from drugs for some people for some problems. The largest single category of prescriptions in the past few years is for drugs that alter feeling and mood. Billions of doses of anti-anxiety and anti-depressant drugs are prescribed annually. A common social query is "Are you on Happy Pills?" The majority of over-the-counter drugs are advertised and bought for similar purposes —Tranquil, Quiet World, Compose, Sleepeze. A recent Massachusetts Court decision held that alcohol, despite the clearly demonstrated risks involved in its use, was used to relax the tensions resulting from full participation in society as it is and was therefore acceptable. On the oher hand, marijuana despite the recent questioning of assumed risks, was used purely for pleasure and to get "high" and merited its illegal and criminal status.

Socially the problem is for what purposes, other than medical and therapeutic, the use of drugs should be sanctioned—and who should decide. Personally, the problem is philosophical and moral: what kind of a life do I want to live and how do I balance the risks and benefits of drug use in terms of my goals.

Many Problems to Solve

These social, ethical, philosophical and religious problems will not be solved by arguing about safe drugs and dangerous drugs or the social and personal characteristics of people who choose to use certain drugs and of people who choose not to use them. Neither will they be solved by legislation and criminal sanctions.

One thing that might help is to explore with young people how opportunities can be provided for them to develop a meaningful identify, satisfying social relationships, constructive use of their energy, talents, knowledge and significant participation in a complex and rapidly changing society which soon will be in their hands. People who are busy using their particular talents in ways that are personally and socially meaningful and who feel they have at least some influence on their own destiny seldom abuse drugs.

A current program
for alcoholic probationers
and parolees in
the District of Columbia.

REALITY ORIENTATION

BY EDWARD W. SODEN
PROBATION OFFICER
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

Is alcohol addiction more serious than drug addiction in probation and parole case loads? This poses an important and provocative question. The answer lies in an estimated 5 million, although the writer is inclined to estimate that figure at 7 million, alcoholics in this country compared with approximately 64,000 active narcotic addicts recorded with the Federal Narcotic Bureau as of December 31, 1968. Again the writer is of the opinion that a more realistic figure would be 100,000 narcotic addicts. The conclusion, using the larger number in each category, would be that the alcohol addiction problem is 70 times greater and, therefore, a more serious problem in crime. This is further substantiated by the report of the President's Commission on Law Enforcement and Administration of Justice revealing that between 40 to 50 per cent of those incarcerated in penal institutions for felonies in the United States have a drinking problem. The same report also reveals that alcohol-related offenses accounted for 52.6 per cent of all the arrests reported to and by the F.B.I. in 1965.

Most attention today is focused on drug addiction despite the fact that alcohol addiction is the third greatest health problem in the country, and most certainly more deeply involved in crime. Despite this, little, if anything, is actually being done about it. Unfortunately, but all too frequently, it is found that alcoholic treatment and rehabilitation programs are "all talk and little or no action" (see article The "Team" Approach in the Treatment of Alcoholics-Federal Probation Quarterly, June 1968 issue). This article focuses on the contention that the complex alcoholic problem cannot be coped with until a multidisciplinary approach is adopted. It also deals with the "team" approach in dealing with alcoholics.

Most problem drinkers, upon release from penal institutions, return to the community usually under some form of parole supervision. Many of those arrested, but who do not go to prison, are released under some form of probation supervision. With such responsibility, probation and parole officers must be concerned and aware of what should and can be done to help the individual with a drinking problem. This is the type of problem

Age Breakdown

Age Group	19-25	26-30	31-35	36-40	41-45	46-50	51-55	56-60	61-65
Number	8*	9	10	3	5	4	2	0	1

*Includes 2 who were 19

which cannot be handled by wishful thinking. Responsibility lies with the supervising officer to initiate action and follow it through.

Because the Probation Department in the United States District Court for the District of Columbia was aware and concerned with this problem, a group counseling program for alcoholics was begun early in 1965. It is the only such program functioning in the federal system and in similiar agencies in the District of Columbia (see article Constructive Coercion and Group Counseling in the Rehabilitation of Alcoholics-Federal Probation Quarterly, September 1966). Attention, in this article, focuses on "constructive coercion" and the contention that authority can be used constructively and intelligently in helping alcoholics under probation and parole supervision.

This program has continued over the years, and to better understand the background and problems of those involved in the last group conducted by the program, the following information is presented, together with results.

A total of 42 was enrolled in the group which met weekly, in the evening after official hours, for 25 weeks, at no expense to the government.

The following is a simple statistical breakdown of the group with respective comments.

This chart reveals that 8, or 19% of the group, were in the age bracket of 19-25 years old. The 26-30 group represented 21%, while the largest group, 31-35, represented 23%. The interesting fact is that the age bracket 19-35 represented 63% of the total group. Consequently, the group worked with was a comparatively young group, and coincides with general observations of the population throughout the country, that the problem is affecting more young people than heretofore. However, it must be noted that with the knowledge and information now available, the problem is being detected at an earlier age.

Marital Status

Status	Single	Married	Separated	Divorced	Widowed
Number	15	10	15	1	1

Fifteen were in the separated category and represented 35% of the total group. Admittedly, the drinking problem was the paramount factor in causing the separation and again emphasizes that alocholism affects the entire family and must be considered as a family disease. It also explodes the alcoholic's myth "when I drink I hurt only myself."

Employment Status at time of sentence

Employed	23*
Unemployed	19

*Included part time and irregular work

Despite including part time and irregular work under the category of employed, the totally unemployed group of 19 represented 45% of the

total group. This large percentage focuses attention on the effects of alcoholism, and particularly the family dependency problem so created by uncontrolled drinking.

Admitted a Drinking Problem

Yes	15
No	27

Twenty-seven or 64% did not admit a problem when they first entered the group and emphasizes the difficulty of working with such individuals. Denial of a drinking problem is the usual pattern and until such denial is broken down little of a positive nature can be anticipated.

Offense

Against Persons	12
Against Property	30

Crime against property committed by 30 represented 71% of the total group. This percentage, in the main, consisted of Unauthorized Use of Vehicle. This appears somewhat unusual since most authoritative studies reveal the highest percentage involve crimes against persons.

Extent Alcohol Was Involved in Offense

Excessive	27
Limited	9
None	6

The 27 in the excessive group represented 64% of the group. Interesting to note is that this percentage coincides with the same percentage who did not admit a problem on entering the Group. Compared with other studies this appears as an approximate average.

Referral to Group

By Probation Officer	16
By Special Condition of Probation	26

Twenty-six or 61% were in the Group as a Special Condition of Probation imposed by the Court. In this category, 7 stopped drinking, 5 reduced their drinking and 14 remained unchanged when the Group concluded its meetings.

Of the 16 referred by their Probation Officers, 3 stopped drinking, 3 reduced their drinking and in 10 instances there was no change.

Effect of Constructive Coercion

(Based primarily on changed attitudes and not on drinking alone.)

Full	17
Limited	7
None	18

This phase of group dynamics is based on the premise that there is tremendous therapy in authority provided that the authority is used constructively and intelligently.

Is Constructive Coercion constructive? (See article of same title, *Inventory,* Oct-Dec. 1967 issue). This article, based on an evaluation and conclusion of the alcoholic counseling program, concluded without question that "constructive coercion"—forced exposure—produced positive results in spite of negative attitudes.

Approximately 40% shown in the above chart changed their attitudes noticeably during group and must be considered a positive result of constructive coercion. Only by such change in attitudes and thinking patterns can positive results be effected.

Results

(Based on observation by group leader and statements by the participants.)

Stopped Drinking	10
Reduced drinking	8
No change	24

The above chart indicates 10 or 23% stopped drinking while 8 or 19% reduced their drinking. In this specialized field it is difficult to measure success since actually there is no cure

for alcoholism. It can, however, be arrested. There is only one solution and that is complete and total abstinence. Therefore, if one returns to drinking, the problem is reactivated and usually is more progressive, insidious and disastrous than before. Success, however, can be measured by an individual working more regularly than before, displaying concern and action toward his family obligations, paying his share of taxes, improved health and a better outlook on life even if there has only been a reduction in drinking. In addition, there is no way to measure the seeds which have been planted and which, hopefully, will bear fruit at a later date.

One working in this particular and specialized field readily realizes that relapses must be anticipated although not necessarily condoned. Also, alcoholics must usually experience some sort of a crises situation to break down the wall of denial that a drinking problem exists, and which is usually the bulwark of defense with which the alcoholic surrounds himself.

Original Program

The original program consisted of a simple format. Through an Alcoholics Anonymous oriented program, used primarily because AA is undeniably the most successful program to date, the individual was made aware of his problem, knowledgeable in the problem and helped to become motivated and informed as to where and what continuing help in the community was available to him. Group discussion, educational films, talks by carefully *selected* AA members, talks by selected professionals in the field of alcoholic treatment, "chalk talks," and simple role playing were all a part of the program. Every effort was directed toward helping the individual to become honest with himself in admitting and accepting the problem and, then, in wanting help. As an additional phase of operant conditioning, a certificate of participation was awarded to all who maintained a satisfactory record of attendance.

The problem of alcoholism is very complex and there is no one or simple answer. Alcoholism in case loads does cause problems. Behavior fluctuates from good to bad and the problems, are multiple, i.e., marital, employment, social, financial, health and mental. Frequently with sobriety many of these problems resolve themselves. When we understand alcoholism, then we realize that the alcoholic is continually recovering and, therefore, without sobriety little, if anything, permanent can be achieved.

Hopefully at a later date time will permit a follow-up study to determine the status of those reported upon in this resume to determine continuous sobrietry or if seeds that were sown have borne fruit.

To determine whether or not a more successful approach to the alcoholic problem in probation and parole case loads was possible, the format for Group No. 6 has been revised to a degree.

Educational techniques used in this revised format of The Reality Orientation Group Program for Alcoholics now being conducted stems from the possibility of dealing more effectively with the practical problem of alcoholism involved in the case loads of probation officers. After a year a comparison study will be made to determine the effectiveness and results of each.

The program has always operated on the premise that knowledge brings understanding. Hopefully, with understanding comes motivation to attempt self-help. An important purpose of the Group is to train people to think. If this can be accomplished in an interesting manner, with boredom eliminated, then one can look forward to accomplishment.

(Continued on Page 29)

The Alcoholic As Job Applicant and Worker

BY ROBERT L. STEVENS

The Alcoholic Applicant for a job tends to fall into one of three categories:

1) The person who has never tried any kind of therapy or treatment; he is not a good risk.

2) The person who tried some kind of treatment program at one time, perhaps years ago, but who is not *currently* involved in such a program; he tends to be about as poor a risk as the first man.

3) The person who is involved *now* in a therapy program; he is the best candidate of these three "types."

In evaluating an alcoholic applicant for a job, three questions seem appropriate:

1) Is he currently involved in a treatment program?

2) Is he qualified to do the work you have for him to do, using the same tests, measuring procedures and screening criteria you normally use in evaluating an applicant's skills, intelligence, interests, aptitudes and personality?

3) Do *you*, personally, feel comfortable with him? Or, are you so afraid you will offend him, make him angry, or frighten him, that the interview becomes a contest between egg-shell walkers? Don't be afraid to respect your intutition or *personal* response to him as you sit with him face-to-face. If he has made any progress in therapy, it will show in his ability to establish and tolerate rapport with people. After all, *people* are his problem, not alcohol!

In evaluating an alcoholic job applicant, here are some questions that are *not* as important as they might seem:

1) When did he have his last drink? A person who is involved in therapy might have taken a drink, or gotten very drunk, just last week and still be an excellent candidate for a job. And the man who has been dry for a year might have been paying an extremely high price for that sobriety, emotionally speaking, and might fall apart as soon as you hire him.

2) How good are his references? References have value, yes, but remember to allow for *recent change* in a person. Obtain and consider a reference from his *treatment source* along with the others. The extent to which a man is "working" in therapy is a good indication of how well he will work for you.

3) What kind of work history does he have? Work histories require careful study and interpretation if great importance is to be placed on them in evaluating a man's stability and value. A work history contains what a man has done vocationally, but it also contains the response that one or more employers have made to that

Robert L. Stevens is a rehabilitation specialist for alcoholic cases in the Georgia Office of Rehabilitation Services, The Georgian Clinic, Atlanta, Georgia.

man. It is a combination of complicated relationships, and the story can't really be told to a paper form. It has to be discussed face-to-face.

The Alcoholic Employee

There are certain relationships that tend to develop between an alcoholic employee and his employer that are usually destructive:

1) The employer should not become a "therapist" to the employee. Attempts to "help" alcoholics on a one-to-one basis are almost invariably not successful and, by becoming the employee's therapist, the employer gives up his role as the employer (which is just as important in itself).

2) The employer should not become a "protector" to the employee. The attitude that says to the alcoholic, "I have to take care of you. I must keep you from drinking. I must protect you from the consequences of your drinking if you do drink," is actually a *rejection* of the *strength* of the alcoholic! It says to him, "Without me, you don't stand a chance." Interestingly, many "protectors" actually wind up helping the alcoholic to obtain a drink!

3) The employer should not become a "detective" to the alcoholic employee. Perhaps the best approach is to forget that the alcoholic is an alcoholic after he's hired. Believe what he says, respect his right to privacy, to get angry, to be frustrated, to get sick, and to be less effective at some times than at others—to the same extent that you would allow such behavior on the part of other employees.

On the job, the alcoholic needs:

1) A supervisor who is available, and accessible; who makes his expectations clear, and who is firm in the way he follows through after orders are given and limits are set—consistently.

2) Limits on his working hours. The alcoholic tends to overwork or take *too much* responsibility for seeing that the job gets done. This may sound like a virtue, but is a potentially harmful attitude.

3) Careful evaluation prior to a promotion of any kind. How will the promotion really *change* his job? Does he *want* the change, or just feel that he *has* to accept it? A promotion might be inappropriate now, but appropriate three months from now.

JOB APPLICANT AND WORKER

(CONTINUED FROM PAGE 27)

Instead of the previous on-going group technique, the revised program consists of the group meeting weekly over a three-month period. The meetings continue to be held after official hours at no cost to the government or to those we are trying to help. Through a series of lectures on alcoholism, the disease, its development and progression, "chalk talks," using blackboard illustrations, diagrams and outlines, in depth group discussion, talks by *selected* AA speakers and others, educational films, as well as simple role playing, the individual is brought face to face with reality. Through such reality he, hopefully, will admit and face his problem and follow through, at the conclusion of the series of meetings, with a program of action outlined for him, consisting primarily of Alcoholics Anonymous or other available community resources, to foster an attitude of self-help. The program provides a strong, vigorous and directive approach which has been designed to eliminate passive dependency.

Through this program we believe we can help people to stop running away from their problem and instead to face reality. We would like to think of this program as a repair shop for human beings which enables them to escape from their junk yards of human misery.

MEASURING SUCCESS

(CONTINUED FROM PAGE 15)

critical evaluation. If there are institutions of which this is not true, they are rare and worthy of imitation. With regard to means of comparison among the various treatment facilities and techniques, we are in the Dark Ages. It is in part understandable that we have a fair amount of suspicion and competition between the several treatment systems. There are few hard facts to dispell our common ignorance of what has happened to the people we treat.

This, then, is a plea that we begin to develop responsible standards, effective data gathering systems, and accurate reporting practices. This must be done cooperatively—probably under the aegis of the State Council on Alcoholism or the Alcoholism Section of the State Health Department But it must be a cooperative effort. Consensus among treatment agencies is essential if we are to produce comparable statistics and worthwhile evaluation.

This task will be slow and difficult. For example, measures of success will be complex—not simple. Various systems will stress their own peculiar emphasis. A meeting of minds will come slowly. We must acknowledge that accurate reporting by former patients and their families will be difficult to come by, since alcoholism is still a hush-hush subject for so many people. Just reaching former patients is a problem. Many alcoholics are unusually mobile, so they are readily lost. "Address unknown" appears on a high percentage of envelopes returned to a treatment center which serves alcoholics near the bottom of the socio-economic scale.

The cost of gathering such data and assembling reports is a factor in a field as ill-financed as alcoholism treatment.

Should we, perhaps, forget the whole idea, continue to "fly by the seat of our pants," rescue as many alcoholics as we can, and let our failures slip off into oblivion? This would have the immediate advantage of keeping our energies focused on the suffering patients at hand, of which we are promised an inexhaustible supply—but it would allow us to perpetuate ineffectual or even harmful procedures which a study of our results might reveal. It would also dwarf the degree to which we can learn from each other.

Also involved is our desire to give status to alcoholism as an illness of major proportions and to treatment as a viable approach to the disease. People working in the health field can only be amused or dismayed at our lack of common measurement and the informality of our statistical work.

So, I propose that we set ourselves to the task. I do not have a plan to put forth, but there are some convictions which ought to be fed into the hopper as we go about it.

In establishing measurements of success, the following should be considered:

1) There must be some recognition of the phase of the illness prior to treatment. We compare apples and oranges if we ignore the differences between the 21-year old problem drinker and the 65 year old wino; or the employee sent for his first treatment venture as a condition of his job, and the individual who has already run the gamut of treatment centers and is still hard at work destroying himself. Measurement must be rendered in relation to the starting point of the patient as well as where he emerges.

2) The record of drinking after treatment must be more detailed than a simple "drunk" or "sober". Frequency and length of remissions is extremely germane to accurate eval-

uation of the treatment.

3) However it may be stated, the primary measurement of effectiveness must be improvement in the patient's ability to handle his life. Significant improvement is a more viable goal than mere sobriety measured in months or years. Improvement would be evidenced by such factors as quality of personal relationships (with spouse, family, etc.), employment stability, condition of health, etc.

A data-gathering and reporting system must include these provisions:

1) Information must be garnered through first-hand contact with the patient and with some other person referral source, family member, etc.) if at all possible. Since self-protection and deception are frequent elements in the alcoholic syndrome, cross-checking of information is called for. Less immediate sources of information should be ignored as bases of statistical study.

2) Statistics must include only solid information. Some guidelines concerning admissable types of data should be written for the sake of sharing accurate information.

3) Reports for distribution should be in categories of standard measurements as established by a responsible agency and subscribed to by each participating treatment facility. It is possible that only a portion of the facilities in the field will choose to join in this effort. It should proceed with those who will cooperate.

Consequences of this entire development would not be immediate and simple clarification of the present muddled situation. The well-evaluated and accurately reported results of treatment will produce much detail, yielding their value primarily to those who will give serious attention. This should not deter us. We are called to a serious task. The results will be monumental in terms of effective treatment and improved lives.

INDUSTRIAL PROGRAM

(CONTINUED FROM PAGE 7)

6) Company and union policy allowed for dismissal of employees in keeping with good personnel procedures when reasonable rehabilitation efforts failed.

The Neuse Clinic, Alcohol Information Division (the present name of the organization previously referred to in this report as the Alcohol Information Center and later the Alcoholism Division of the Neuse Mental Health and Alcoholism Center), had a number of "lucky breaks," too numerous to mention here, during the approximately two years that it took for this industrial program to fully develop. One that does deserve some mention is an article that appeared in the January, 1970 issue of Federal Times, weekly newspaper circulated nationally for Federal Civil Service workers, which headlined the seriousness of the drinking problem among Federal employees. The article pointed out that there were at least 160,000 problem drinkers in the Federal Civil Service work force and that each one cost the Federal Government $1,600.00 per year in lost time through absences alone.

Since the counseling service was established at N.A.R.F. in early December, 1969, about twenty-five *admitted* problem drinkers have been counseled and referred to either inpatient or outpatient treatment resources. This case load is expected to grow as time allows the excellent working relationship established between the company doctor, the supervisors and counselors to make its mark on the effectiveness of the program. To date, the personnel of the Neuse Clinic have found this program to be most successful and satisfactory to all parties because of the assistance and cooperation from all the people involved.

DIRECTORY OF OUTPATIENT FACILITIES BY COUNTY —for ALCOHOLICS and/or THEIR FAMILIES

Key to Facilities

+ Community Alcoholism Program
(supported jointly by the community and the N. C. Department of Mental Health)

*** Community Alcoholism Program**
(supported largely by funds from local boards of alcoholic beverage control)

‡ Joint Mental Health and Alcoholism Services
(supported by the community and the N. C. Department of Mental Health)

† Mental Health Facility
(supported by the community and the N. C. Department of Mental Health whose services are available to alcoholics and their families)

Competent Help Is Available At The Local Level

ALAMANCE—

\+ *Alamance County Council on Alcoholism*, Room 802, N. C. National Bank Bldg., Burlington 27215; Tel: 919-226-4403.

† *Alamance County Mental Health Clinic*, 221 Graham-Hopedale Rd., Burlington 27215; Tel: 919-227-6271.

ALLEGHANY (See Watauga)

ANSON—

† *Anson County Health Department*, Wadesboro 28170; Tel: 704-694-2516.

* *Education Division, Board of Alcohol Control*, 127 Wade St., P. O. Box 39, Wadesboro 28170; Tel: 704-694-2711.

AVERY (See Watauga)

BEAUFORT (Hyde, Martin, Tyrrell, Washington)—

† *Tideland Mental Health Center*, 418 West Second St., Washington 27889; Tel: 919-946-4640.

BERTIE (Hertford, Northampton, Gates)—

† *Roanoke-Chowan Mental Health Service*, 316 South Academy St., Ahoskie 27810, Tel: 919-332-4137 (main office); and 108 Dundee St., P. O. Box 143, Windsor 27983, Tel: 919-794-2895 (sattelite).

BLADEN (See Robeson)

BUNCOMBE—

† *Alcohol Information Center*, Parkway Offices, Asheville 28802; Tel: 704-252-8748.

† *Mental Health Center of Buncombe County*, 415 City Hall, Asheville 28801; Tel: 704-254-2311.

BURKE—

* *Burke County Council on Alcoholism*, 211 N. Sterling St., Morganton 28655; Tel: 704-443-1221.

CAMDEN (See Pasquotank)

CARTERET (See Craven)

CABARRUS—

† *Cabarrus Mental Health Complex*, 102 Chruch St., N.E., Concord 28025; Tel: 704-786-1181.

CATAWBA—

* *Catawba County Council on Alcoholism*, 420 Seventh Ave., S.W., Hickory 28601; Tel: 704-328-3564.

CHOWAN (See Pasquotank)

CLEVELAND—

† *Cleveland County Mental Health Clinic*, 101 Brookhill Rd., Shelby 28150; Tel: 704-482-3801.

CRAVEN (Carteret, Jones, Pamlico)—

‡ *The Neuse Clinic*, 2000 Neuse Blvd.:

\+ *Alcohol Information Division*, P.O. Box 2535, New Bern 28560; Tel: 919-638-4171.

\+ *Alcohol Information Division*, 506 Broad St., P. O. Box 82, Beaufort 28516; Tel: 919-728-4033.

COLUMBUS (See Robeson)

CUMBERLAND—

† *Cumberland County Mental Health Center*, Cape Fear Valley Hospital, Fayetteville 28302; Tel: 919-484-8123.

CURRITUCK (See Pasquotank)

DARE (See Pasquotank)

DUPLIN (See Onslow)

DURHAM—

† *Department of Psychiatry*, Duke University Medical Center, Durham 27706; Tel: 919-684-8111, Ext. 3416.

Durham Council on Alcoholism, 602 Snow Bldg., Durham 27702; Tel: 919-682-5227.

EDGECOMBE (NASH)—

† *Edgecombe-Nash Mental Health Center*, 359 Falls Rd., P. O. Box 2312, Rocky Mount 27801; Tel: 919-442-8021.

FORSYTH—

† *Department of Psychiatry*, Bowman Gray School of Medicine, N. C. Baptist Hospital, Winston-Salem 27103; Tel: 919-725-7261.

† *Forsyth County Department of Mental Health:*

† *Alcoholism Program of Forsyth County*, 802 O'Hanlon Bldg., 105 W. 4th St., Winston-Salem 27101; Tel: 919-725-5359.

† *Forsyth County Mental Health Unit*, 1020 E. 7th St., Winston-Salem 27101; Tel: 919-722-0364.

FRANKLIN—

† *Franklin County Family Counseling and Education Center*, Rt. 1, Box 1X West, River Rd., Louisburg 27549; Tel: 919-496-4111.

† *Gaston County Mental Health Center:*

† *Center for Alcohol Related Problems*, 302 S. York St., Gastonia 28052; Tel: 704-864-9771.

GATES (See Bertie)

GUILFORD—

* *Alcohol Education Center*, P. O. Box 348, Jamestown 27282; Tel: 919-454-2794.

Family Service Agency, 1301 N. Elm St., Greensboro 27401; Tel: 919-273-0523.

Family Service Agency of High Point, 113 Gatewood Ave., High Point 27260; Tel: 919-883-1709 or 919-833-2119.

† *Greensboro Council on Alcoholism*, 216 W. Market St., 206 Irvin Arcade, Greensboro 27401; Tel: 919-275-6471.

† *Guilford County Mental Health Center*, 300 E. Northwood St., Greensboro 27401; Tel: 919-273-8281.

† *Guilford County Mental Health Center*, 942 Montlieu Ave., High Point 27262; Tel: 919-888-9929.

HALIFAX—

† *Halifax County Mental Health Center*, 701 Jackson St., P. O. Box 577, Roanoke Rapids 27870; Tel: 919-537-6174.

HARNETT (See Lee)

HENDERSON—

* *Alcohol Information Center*, 2nd Floor, City Hall, P. O. Box 472, Hendersonville 28739; Tel: 704-692-8118.

† *Henderson County Mental Health Clinic*, 820 Fleming St., Hendersonville 28739; Tel: 704-692-2138.

HERTFORD (See Bertie)

HOKE (See Moore)

HYDE (See Beaufort)

IREDELL—

† *Iredell County Mental Health Clinic*, 221 South Center St., Statesville 28677; Tel: 704-872-7901.

JONES (See Craven)

LEE (Harnett)—

† *Lee-Harnett Mental Health Clinic:*

\+ *Division on Alcoholism*, 106 W. Main St., P. O. Box 2428, Sanford 27330; Tel: 919-755-4129 or 919-755-4130.

LENOIR—

† *Lenoir County Mental Health Clinic*, 111 South McLewean St., Kinston 28501; Tel: 919-527-1196.

MARTIN (See Beaufort)

MECKLENBURG—

* *Charlotte Council on Alcoholism*, 1125 E. Morehead St., Charlotte 28204; Tel: 704-375-5521.

† *Mecklenburg County Mental Health Center*, 316 E. Morehead St., Charlotte 28202; Tel: 704-334-2834.

* *The Randolph Clinic, Inc.*, 1804 East Fourth St., Charlotte 28204; Tel: 704-333-9026.

MONTGOMERY (See Moore)

MOORE—

* *Moore County Alcoholism Program*, P. O. Box 1098, Southern Pines 28387; Tel: 919-692-6631.

† Sandhills Mental Health Center (Hoke, Montgomery, Moore, Richmond):

† *Alcoholism Services*, Medical Center Bldg., Pinehurst 28374; Tel: 919-295-6851.

NASH (See Edgecombe)

NEW HANOVER—

* *New Hanover County Council on Alcoholism*, 211 N. Second St., Wilmington 28401; Tel: 919-763-7732.

† *Southeastern Mental Health Center*, 920 S. 17th St., Wilmington 28401; Tel: 919-763-7342.

NORTHAMPTON (See Bertie)

ONSLOW (Duplin)—

† *Onslow-Duplin Mental Health Clinic*, 225 Wilmington Hwy., P. O. Box 547, Jacksonville 28540; Tel: 919-347-5118.

ORANGE—

† *Alcoholism Clinic of the Psychiatric Outpatient Service*, N. C. Memorial Hospital, Chapel Hill 27514; Tel: 919-942-4131, Ext. 336.

* *Orange County Council on Alcoholism*, Box 277, Carrboro 27510; Tel: 919-942-1089 or (if no answer) 919-942-1930.

PAMLICO (See Craven)

PASQUOTANK (Camden, Chowan, Dare, Perquimans, Currituck)—

‡ *Albemarle Area Mental Health and Alcoholism Service*, P. O. Box 645, Medical Bldg., Elizabeth City 27909; Tel: 919-335-1663.

PERQUIMANS (See Pasquotank)

PITT—

† *Coastal Plain Mental Health Center*, 1827 W. Sixth St., Greenville 27834; Tel: 919-752-7151.

\+ *Pitt County Alcohol Information and Service Center*, 907 Forbes St., P. O. Box 2371, Greenville 27834; Tel: 919-758-3159.

RICHMOND (See Moore)

ROBESON (Bladen, Columbus, Scotland)—

† *Southeastern Regional Mental Health Center*, Medical Arts Bldg., Lumberton 28358; Tel: 919-739-7601.

ROCKINGHAM—

† *Rockingham County Mental Health Center*, P. O. Box 55, Wentworth 27375; Tel: 919-349-7021.

ROWAN—

* *Educational Division, Rowan County ABC Board*, P. O. Box 114, Salisbury 28144; Tel: 704-633-1641.

† *Rowan County Mental Health Clinic*, Community Bldg., Main and Council Sts., Salisbury 28144; Tel: 704-633-3616.

SCOTLAND (See Robeson)

TYRRELL (See Beaufort)

VANCE—

† *Vance County Mental Health Clinic*, County Home Rd., Henderson 27536; Tel: 919-492-1176 or 919-438-4813.

* *Vance County Program on Alcoholism*, 158 Bypass W., P. O. Box 1174, Henderson 27536; Tel: 919-438-3274 or 919-483-4702.

WAKE—

† *Mental Health Center of Wake County*, Wake Memorial Hospital, Raleigh 27610; Tel: 919-834-6484.

* *Wake County Health Department*, 3010 New Bern Ave., Raleigh 27610; Tel: 919-833-1655.

WASHINGTON (See Beaufort)

WATAUGA (Alleghany, Avery, Wilkes)—

† New River Mental Health Center:

\+ *Division on Alcoholism*, 210 W. King St., Boone 28607; Tel: 704-264-8759.

\+ *Division on Alcoholism*, 101-A W. Main St., Wilkesboro 28697; Tel: 919-838-3551.

WILSON—

* *Wilson County Council on Alcoholism*, Room 308, 116 S Goldsboro St., Wilson 27893; Tel: 919-237-0585.

† *Wilson County Mental Health Clinic*, Encas Rural Station, Wilson 27893; Tel: 919-237-2239.

WILKES (See Watauga)

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